

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036798</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Rosewood Care Center of Joliet</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2001</u> to <u>6/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>3401 Hennepin Drive</u> <u>Joliet</u> <u>60435</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Will</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(815) 436-5900</u> Fax # () _____		Paid Preparer (Signed) <u>Accountant's Compilation Report Attached</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # (618) 465-7710	
IDPA ID Number: <u>431478199001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>1/31/91</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center of Joliet# 0036798 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>14,000</u>	<u>14,000</u>	8
9	SNF/PED					9
10	ICF	<u>1,926</u>	<u>18,626</u>		<u>20,552</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,926</u>	<u>18,626</u>	<u>14,000</u>	<u>34,552</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.89%

D. How many bed-hold days during this year were paid by Public Aid?

4 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/31/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 1/31/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 58 and days of care provided 14,000Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2002 Fiscal Year: 6/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Rosewood Care Center of Joliet

0036798

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	189,919	25,084	11,348	226,351		226,351		226,351		1
2	Food Purchase		161,487		161,487		161,487	(4,775)	156,712		2
3	Housekeeping	119,748	24,643		144,391		144,391		144,391		3
4	Laundry	43,221	17,705		60,926		60,926		60,926		4
5	Heat and Other Utilities			109,648	109,648		109,648	420	110,068		5
6	Maintenance	12,363	8,736	88,935	110,034		110,034	17,915	127,949		6
7	Other (specify):* Sanitation			20,270	20,270		20,270		20,270		7
8	TOTAL General Services	365,251	237,655	230,201	833,107		833,107	13,560	846,667		8
	B. Health Care and Programs										
9	Medical Director			12,750	12,750		12,750		12,750		9
10	Nursing and Medical Records	1,966,558	190,532		2,157,090		2,157,090		2,157,090		10
10a	Therapy	70,567	12,880	772,661	856,108		856,108	40,489	896,597		10a
11	Activities	65,071	4,153	425	69,649		69,649		69,649		11
12	Social Services	43,276	70	2,360	45,706		45,706		45,706		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,145,472	207,635	788,196	3,141,303		3,141,303	40,489	3,181,792		16
	C. General Administration										
17	Administrative			1,388,681	1,388,681		1,388,681	(1,223,492)	165,189		17
18	Directors Fees										18
19	Professional Services			7,938	7,938		7,938	37,082	45,020		19
20	Dues, Fees, Subscriptions & Promotions			34,082	34,082		34,082	(10,690)	23,392		20
21	Clerical & General Office Expenses	150,587	41,359	17,961	209,907		209,907	165,796	375,703		21
22	Employee Benefits & Payroll Taxes			295,409	295,409		295,409	32,581	327,990		22
23	Inservice Training & Education										23
24	Travel and Seminar			860	860		860		860		24
25	Other Admin. Staff Transportation			5,285	5,285		5,285	18,703	23,988		25
26	Insurance-Prop.Liab.Malpractice			36,710	36,710		36,710	6,517	43,227		26
27	Other (specify):*										27
28	TOTAL General Administration	150,587	41,359	1,786,926	1,978,872		1,978,872	(973,503)	1,005,369		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,661,310	486,649	2,805,323	5,953,282		5,953,282	(919,454)	5,033,828		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Rosewood Care Center of Joliet

#0036798

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					10,667	10,667	196,557	207,224			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,408	21,408		21,408	317,186	338,594			32
33	Real Estate Taxes			59,015	59,015		59,015		59,015			33
34	Rent-Facility & Grounds			1,626,574	1,626,574		1,626,574	(1,613,339)	13,235			34
35	Rent-Equipment & Vehicles			13,850	13,850		13,850		13,850			35
36	Other (specify):*			10,667	10,667	(10,667)						36
37	TOTAL Ownership			1,731,514	1,731,514		1,731,514	(1,099,596)	631,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		396,489	24,561	421,050		421,050	(2,651)	418,399			39
40	Barber and Beauty Shops			3,076	3,076		3,076		3,076			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		396,489	93,337	489,826		489,826	(2,651)	487,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,661,310	883,138	4,630,174	8,174,622		8,174,622	(2,021,701)	6,152,921			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number **Rosewood Care Center of Joliet**

0036798

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,344)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,738)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,651)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(431)	2		13
14	Non-Care Related Interest	(21,408)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,238)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,058)	20		28
29	Other-Attach Schedule Marketing Salary	(56,989)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,857)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,913,844)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,913,844)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,021,701)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Joliet

ID# 0036798

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary	\$ (56,989)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(56,989)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Joliet

0036798

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,775)	0	0	0	0	0	0	0	0	0	0	(4,775)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	420	0	0	0	0	0	0	0	0	420	5
6	Maintenance	0	0	17,915	0	0	0	0	0	0	0	0	17,915	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,775)	0	18,335	0	0	0	0	0	0	0	0	13,560	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	40,489	0	0	0	0	0	0	0	0	0	40,489	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	40,489	0	0	0	0	0	0	0	0	0	40,489	16
	C. General Administration													
17	Administrative	0	(1,388,681)	165,189	0	0	0	0	0	0	0	0	(1,223,492)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	37,082	0	0	0	0	0	0	0	0	37,082	19
20	Fees, Subscriptions & Promotions	(11,296)	0	606	0	0	0	0	0	0	0	0	(10,690)	20
21	Clerical & General Office Expenses	(56,989)	0	222,785	0	0	0	0	0	0	0	0	165,796	21
22	Employee Benefits & Payroll Taxes	0	0	32,581	0	0	0	0	0	0	0	0	32,581	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	18,703	0	0	0	0	0	0	0	0	18,703	25
26	Insurance-Prop.Liab.Malpractice	0	0	6,517	0	0	0	0	0	0	0	0	6,517	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(68,285)	(1,388,681)	483,463	0	0	0	0	0	0	0	0	(973,503)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,060)	(1,348,192)	501,798	0	0	0	0	0	0	0	0	(919,454)	29

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 1,388,681	HSM Management Services, Inc.	100.00%	\$	\$ (1,388,681)	1
2	V							2
3	V	10a Therapy	772,661	Rosewood Therapy Services, Inc.	0.00%	813,150	40,489	3
4	V							4
5	V	34 Rent	1,626,574	Joliet Real Estate, Inc.	0.00%		(1,626,574)	5
6	V	30 Depreciation		Joliet Real Estate, Inc.		172,866	172,866	6
7	V	32 Interest		Joliet Real Estate, Inc.		321,297	321,297	7
8	V	32 Amortization - Loan Fee		Joliet Real Estate, Inc.		28,035	28,035	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,787,916			\$ 1,335,348	\$ * (2,452,568)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798Report Period Beginning: 7/1/2001Ending: 6/30/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 165,189	\$ 165,189
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	222,785	222,785
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	32,581	32,581
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	18,703	18,703
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	23,691	23,691
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,235	13,235
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	37,082	37,082
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	6,517	6,517
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	17,915	17,915
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	420	420
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	606	606
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 538,724	\$ * 538,724

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center of Joliet # 0036798 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	820,942	2.54	6.35%	Salary	\$ 55,638	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	585,094	2.54	6.35%	Salary	39,653	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 95,291		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798Report Period Beginning: 7/1/2001Ending: 7/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Salaries - Officers	Total Cost	78,691,907	17	\$ 1,501,328	\$ 1,501,328	4,994,683	\$ 95,291	1
2	21 Salaries - Others	Total Cost	78,691,907	17	2,971,209	2,971,209	4,994,683	188,587	2
3	22 Payroll Taxes	Total Cost	78,691,907	17	275,345		4,994,683	17,477	3
4	22 Employee Benefits	Total Cost	78,691,907	17	147,178		4,994,683	9,342	4
5	25 Travel	Total Cost	78,691,907	17	280,565		4,994,683	17,808	5
6	30 Depreciation	Total Cost	78,691,907	17	359,545		4,994,683	22,821	6
7	34 Building Rent	Total Cost	78,691,907	17	208,527		4,994,683	13,235	7
8	19 Professional Services	Total Cost	78,691,907	17	584,225		4,994,683	37,082	8
9	21 Telephone	Total Cost	78,691,907	17	234,306		4,994,683	14,872	9
10	26 Insurance	Total Cost	78,691,907	17	102,679		4,994,683	6,517	10
11	21 Taxes, Licenses & Other Sup.	Total Cost	78,691,907	17	304,491		4,994,683	19,326	11
12	6 Maintenance	Total Cost	78,691,907	17	276,408		4,994,683	17,544	12
13	5 Heat & Other Utilities	Total Cost	78,691,907	17	6,619		4,994,683	420	13
14	20 Dues & Subscriptions	Total Cost	78,691,907	17	9,548		4,994,683	606	14
15	17 Direct - Admin	Direct Cost	1	1	69,898	69,898	1	69,898	15
16	17 Direct - Admin	Direct Cost	16	16	918,821	918,821	0	0	16
17	22 Direct - Payroll Taxes	Direct Cost	1	1	5,762		1	5,762	17
18	22 Direct - Payroll Taxes	Direct Cost	16	16	73,254		0	0	18
19	30 Direct - Depreciation	Direct Cost	1	1	870		1	870	19
20	30 Direct - Depreciation	Direct Cost	16	16	15,439		0	0	20
21	25 Direct - Travel	Direct Cost	1	1	895		1	895	21
22	25 Direct - Travel	Direct Cost	16	16	14,932		0	0	22
23	6 Maintenance	Direct Cost	1	1	371		1	371	23
24	6 Maintenance	Direct Cost	16	16	2,855		0	0	24
25	TOTALS				\$ 8,365,070	\$ 5,461,256		\$ 538,724	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America		X	Mortgage	Varies	3/99	\$ 9,789,265	\$ 8,364,638	3/2006	Prm + 1/2	\$ 338,057	1	
2	Less: Related Party Interest Income										(16,760)	2	
3	Amortization of Loan Fees										28,035	3	
4	Interest Income										(10,738)	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 9,789,265	\$ 8,364,638			\$ 338,594	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 9,789,265	\$ 8,364,638			\$ 338,594	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Rosewood Care Center of Joliet**# **0036798**

Report Period Beginning:

7/1/2001

Ending:

6/30/2002**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 86,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 80,839	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (5,761)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 76,720	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ (11,944)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 59,015	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 86,644	8	
	1998 84,379	9	
	1999 84,056	10	
	2000 85,739	11	
	2001 75,939	12	
Payment - \$42,869 - remaining 2000 taxes			
Payment - \$37,970 - 1/2 of 2001 taxes			
Accrual = Remaining 2001 tax bill (37,970) + 1/2 of estimated 2002 tax bill (38,750)			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0036798

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>06-03-26-203-001-0000</u>	<u></u>	\$ <u>75,939.46</u>	\$ <u>75,939.46</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>75,939.46</u></u>	\$ <u><u>75,939.46</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

39,200

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	39,200	1990	\$ 230,225	1
2					2
3	TOTALS	39,200		\$ 230,225	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

0036798

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1990	\$ 3,475,917	\$	25	\$ 139,037	\$ 139,037	\$ 1,668,444	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	General Requirements		1991		25,516		25	1,021	1,021	11,742	9
10	Developer Fee		1991		28,980		25	1,159	1,159	13,329	10
11	Construction Period Interest		1991		20,364		25	815	815	9,373	11
12	Arch and Eng Fees		1991		4,459		25	178	178	2,047	12
13	Storm Sewer		1991		32,675		25	1,307	1,307	15,031	13
14	Lawn Sprinkler		1991		10,990		25	440	440	5,060	14
15	Landscaping		1991		55,127		25	2,205	2,205	25,358	15
16	Mass Grading		1991		54,747		25	2,190	2,190	25,185	16
17	Asphalt Paving		1991		48,390		25	1,936	1,936	22,264	17
18	Sanitary Sewer		1991		8,069		25	323	323	3,715	18
19	Water Line		1991		15,500		25	620	620	7,130	19
20	Driveway and Sidewalks		1991		55,932		25	2,237	2,237	25,726	20
21	Walk-in Cooler Refrigerator		1991		6,888		20	344	344	3,956	21
22	Sink		1991		2,049		10			2,049	22
23	Exhaust and Air Hood		1991		4,670		10			4,670	23
24	Fire Exting. System		1991		1,647		10			1,647	24
25	Combo. Range/Hood		1991		3,925		10			3,925	25
26	Building Signage		1991		7,300		10-15	304	304	6,230	26
27	Generator/Accessories		1991		15,764		20	788	788	9,062	27
28	Cubicle Curtain Track		1991		6,176		10			6,176	28
29	6 Stainless Doors		1991		2,685		10			2,685	29
30	Monument Sign		1991		3,193		10			3,193	30
31	Wallcovering		1991		19,849		10			19,849	31
32	Carpeting		1991		9,585		10			9,585	32
33	Nurse Call System		1991		28,217		20	1,411	1,411	16,227	33
34	Fire Alarm System		1991		15,724		20	786	786	9,039	34
35	Continued on Next Page										35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Door Bell	1991	\$ 1,026	\$	20	\$ 51	\$ 51	\$ 587		37
38	Door Alarm	1991	5,773		20	289	289	3,324		38
39	Public Address	1991	5,022		20	251	251	2,887		39
40	Cable	1991	15,712		20	786	786	9,039		40
41	Hot Water Boiler	1991	6,792		10			6,792		41
42	Hot Water Heater	1991	7,841		10			7,841		42
43	Load Bank Generator	1997	3,945		10	395	395	2,107		43
44										44
45	Leasehold Improvements - Facility:									45
46	Painting/Baseboards/Tiling	1995	14,902	1,190	7	1,190		14,902		46
47	Carpeting	1996	4,157	594	7	594		3,839		47
48	Floor Drain	1997	1,604	229	7	229		1,069		48
49	Entry Floor Mat	1999	1,213	173	7	173		577		49
50	Ceiling Tiles	1999	1,820	260	7	260		845		50
51	Plants	1999	2,441	349	7	349		1,105		51
52	Wallpaper/Wallpaper Install/Blinds	1999	14,251	2,036	7	2,036		6,754		52
53	Air System	1999	13,860	1,980	7	1,980		6,105		53
54	Carpeing	1999	14,300	2,043	7	2,043		5,618		54
55	Computer Cabling	2000	2,392	342	7	342		542		55
56										56
57										57
58	Leasehold Improvements - Management Company:									58
59	Office Construction/Improvements	1995	486		5			486		59
60	Office Design	1995	44		5			44		60
61	Office Shelving	1996	104		4			104		61
62	Office Expansion	1996	459		4			459		62
63	Office Expansion	1997	1,228		3			1,228		63
64	Office Expansion	1998	693		3	51	51	693		64
65	Office Addition	1999	342		3	114	114	342		65
66	Door Locks	1999	171		3	57	57	147		66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,084,916	\$ 9,196		\$ 168,291	\$ 159,095	\$ 2,010,133		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 266,746	\$ 1,267	\$ 29,546	\$ 28,279	5-7 Yrs	\$ 150,287	71
72	Current Year Purchases	16,837	204	1,733	1,529	5-7 Yrs	1,733	72
73	Fully Depreciated Assets	504,260					504,260	73
74								74
75	TOTALS	\$ 787,843	\$ 1,471	\$ 31,279	\$ 29,808		\$ 656,280	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 31,213	\$	\$ 7,654	\$ 7,654	5 Yrs	\$ 20,947	76
77										77
78										78
79										79
80	TOTALS			\$ 31,213	\$	\$ 7,654	\$ 7,654		\$ 20,947	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,134,197	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,667	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 207,224	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 196,557	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,687,360	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					Units	Cost					
1	Licensed Occupational Therapist	10a-8	hrs	\$		31,856	\$ 389,983	\$	31,856	\$ 389,983	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs			2,186	33,589		2,186	33,589	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-8	hrs			34,639	389,578	12,880	34,639	402,458	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-8	# of prescrpts					378,605		378,605	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Ambulance, X-Ray, Enterals Other (specify): & Lab Supplies	39-8						39,794		39,794	13
14	TOTAL			\$		68,681	\$ 813,150	\$ 431,279	68,681	\$ 1,244,429	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 546,284	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	1,505,932		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	13,402		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,065,618	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	82,913		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(45,361)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 37,552	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,103,170	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,041,805	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	219,571		29
30	Accrued Salaries Payable	235,980		30
31	Accrued Taxes Payable (excluding real estate taxes)	263,844		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,720		32
33	Accrued Interest Payable	10,616		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	340,835		36
37	Accrued Rent	(130,781)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,058,590	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,058,590	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 44,580	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,103,170	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,253	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,253	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	726,727	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(713,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 13,327	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 44,580	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,662,554	1
2	Discounts and Allowances for all Levels	(3,694,105)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,968,449	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,289,426	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,289,426	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,243	13
14	Non-Patient Meals	4,344	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,587	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,738	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,738	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	1,329	28
28a	Lab Discounts	2,651	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,284,180	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	833,107	31
32	Health Care	3,141,303	32
33	General Administration	1,978,872	33
	B. Capital Expense		
34	Ownership	1,731,514	34
	C. Ancillary Expense		
35	Special Cost Centers	424,126	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,174,622	40
41	Income before Income Taxes (line 30 minus line 40)**	1,109,558	41
42	Income Taxes	(382,831)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 726,727	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of Joliet# 0036798Report Period Beginning: 7/1/2001Ending: 6/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,025	2,131	\$ 62,258	\$ 29.22	1
2	Assistant Director of Nursing	2,110	2,221	49,041	22.08	2
3	Registered Nurses	27,419	28,859	607,487	21.05	3
4	Licensed Practical Nurses	23,103	24,316	415,556	17.09	4
5	Nurse Aides & Orderlies	72,026	75,807	779,048	10.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,115	5,383	70,567	13.11	8
9	Activity Director					9
10	Activity Assistants	6,508	6,850	65,071	9.50	10
11	Social Service Workers	4,027	4,239	43,276	10.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,546	22,677	189,919	8.37	15
16	Dishwashers					16
17	Maintenance Workers	1,141	1,201	12,363	10.29	17
18	Housekeepers	15,531	16,347	119,748	7.33	18
19	Laundry	5,809	6,114	43,221	7.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,386	14,089	150,587	10.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,176	4,395	53,168	12.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,922	214,629	\$ 2,661,310 *	\$ 12.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	515	\$ 11,348	1-3	35
36	Medical Director	Contract	12,750	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	425	11-3	44
45	Social Service Consultant	130	2,360	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	670	\$ 26,883		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ Section Not Applicable		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

0036798

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Joliet

STATE OF ILLINOIS

0036798

Report Period Beginning: 7/1/2001

Page 23

Ending: 6/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,736 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,344
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: C.J. Schlosser & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not finished
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER OF JOLIET
IDPH ID #0036798
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2002

RELATED NURSING HOME:

ROSEWOOD CARE CENTER OF ALTON
ROSEWOOD CARE CENTER OF EAST PEORIA
ROSEWOOD CARE CENTER OF EDWARDSVILLE
ROSEWOOD CARE CENTER OF ELGIN
ROSEWOOD CARE CENTER OF GALESBURG
ROSEWOOD CARE CENTER OF INVERNESS
ROSEWOOD CARE CENTER OF MOLINE
ROSEWOOD CARE CENTER OF NORTHBROOK
ROSEWOOD CARE CENTER OF PEORIA
ROSEWOOD CARE CENTER OF ROCKFORD
ROSEWOOD CARE CENTER OF ST. CHARLES
ROSEWOOD CARE CENTER OF ST. LOUIS
ROSEWOOD CARE CENTER OF SWANSEA

CITY:

ALTON, IL
EAST PEORIA, IL
EDWARDSVILLE, IL
ELGIN, IL
GALESBURG, IL
INVERNESS, IL
MOLINE, IL
NORTHBROOK, IL
PEORIA, IL
ROCKFORD, IL
ST. CHARLES, IL
ST. LOUIS, MO
SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

HSM MANAGEMENT SERVICES, INC.
JOLIET REAL ESTATE, INC.
HSM DEVELOPMENT, INC.
RCC HOLDING COMPANY
ROSEWOOD HOME HEALTH
ROSEWOOD THERAPY SERVICES

TYPE OF BUSINESS:

MANAGEMENT CO.
REAL ESTATE LSG.
DEVELOPMENT CO.
HOLDING COMPANY
HOME HEALTH CO.
THERAPY COMPANY

ROSEWOOD CARE CENTER OF JOLIET
IDPH ID #0036798
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2002

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT **	\$5,285
	<u>5,285</u>

** ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS
SUBMITTED WHICH WERE LESS THAN \$250.00 EACH.

ROSEWOOD CARE CENTER INC. OF JOLIET
RECLASSIFICATIONS
06/30/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
OTHER	36	(10,667)
DEPRECIATION	30	10,667
TO RECLASS DEPRECIATION EXPENSE DUE TO PROTECTED CELL		